
PREVALENCE AND SOCIODEMOGRAPHIC CORRELATES OF DEPRESSION AMONG LGBTQ+ YOUTH ACCESSING COMMUNITY-BASED ORGANISATIONS IN COASTAL KENYA

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Publication Date: September 2026

ABSTRACT

Background: LGBTQ+ (lesbian, gay, bisexual, transgender and other sexual and gender minority) youth face high stigma and discrimination, and studies elsewhere link this to high rates of depression. Little is known about how common depression is among LGBTQ+ youth in Kenya.

Purpose of the Study: This study measured depression among LGBTQ+ youth attending two community organisations in Mombasa County, and whether it was linked to education, income, employment, insurance, household size or living arrangement.

Methods: A survey was conducted among 324 LGBTQ+ youth aged 20 to 35 years attending two community-based organisations. Depression was measured with a standard depression questionnaire (BDI), and results were compared across social and economic groups using chi-square tests and regression. Data were analysed in IBM SPSS Statistics version 29.

Results: Depression was present in 60.2% of participants, with 34% scoring moderate to very severe. No sociodemographic factor tested, education, household size, living arrangement, insurance, healthcare payment method, employment or income, was significantly linked to depression.

Conclusions: Depression is very common among LGBTQ+ youth in this setting and affects people across all backgrounds fairly equally, pointing to identity-related stigma rather than poverty as the likely driver. Routine depression screening for all LGBTQ+ youth accessing community services is recommended, regardless of social or economic background.

Keywords: *Prevalence, Sociodemographic, Depression, LGBTQ+ Youth, Accessing Community-Based Organisations*

INTRODUCTION

Depression is a leading cause of disability worldwide, and LGBTQ+ (lesbian, gay, bisexual, transgender and other sexual and gender minority) youth consistently show markedly higher rates of it than their heterosexual and cisgender peers (World Health Organization [WHO], 2022; Russell & Fish, 2020). This disparity is attributed not to sexual orientation or gender identity itself, but to the cumulative toll of stigma, discrimination, rejection and concealment that this population disproportionately faces, a mechanism formalised as Minority Stress Theory (Meyer, 2003, 2021). In Kenya, where consensual same-sex conduct remains criminalised and religious and cultural norms often frame LGBTQ+ identities as deviant, these stressors are arguably more entrenched than in the settings where most international evidence originates (Korhonen et al., 2022; Chitembo et al., 2022). Community-based organisations (CBOs) have become one of the few settings where LGBTQ+ youth can safely access psychosocial support, yet published, instrument-based prevalence estimates of depression among LGBTQ+ youth in Kenyan CBOs remain scarce.

This gap has practical implications: without a reasonably precise prevalence estimate, CBOs and funders have little basis for sizing mental health programming or advocating for dedicated budget lines. Existing Kenyan research has more frequently documented stigma and discrimination qualitatively than measured depression using standardised instruments (Logie et al., 2022), and regional reviews report elevated depression across sub-Saharan African sexual and gender minority populations without producing a Kenyan CBO-specific prevalence figure (Müller et al., 2021). This article describes the prevalence of depression, as measured by the Beck Depression Inventory, among 324 LGBTQ+ youth aged 20 to 35 who attend two CBOs in Mombasa County, Njansiangu and Kenya Margins Africa, and investigates whether depression varies across seven socioeconomic characteristics. A key prediction tested here, based on Minority Stress Theory, is that because identity-related stress affects LGBTQ+ people regardless of social or economic status, depression should appear broadly across sociodemographic groups rather than concentrated among the traditionally disadvantaged, as seen in general-population research (Hatzenbuehler & Pachankis, 2021). The article is limited to this baseline, descriptive evidence. The effectiveness of a subsequent psychological intervention delivered to a subset of respondents is reported separately.

METHODOLOGY

A cross-sectional survey design was used to report the baseline component of a larger evaluation of Mindfulness-Based Cognitive Therapy among LGBTQ+ youth in Kenya; no intervention had been delivered at this time. The study was carried out by two CBOs in Mombasa County, Njansiangu and Kenya Margins Africa, which both provide psychosocial support to LGBTQ+ youth aged 20 to 35. Participants were recruited using convenience sampling, with assistance from CBO staff, which was a pragmatic approach given the lack of a sampling frame for this population. The Yamane formula was used to estimate the required sample size of 425 (adjusted for 10% attrition); after data cleaning, 324 valid responses were retained (76.2% response rate). A sociodemographic questionnaire asked about education, household size, living situation, health insurance, healthcare payment method, employment status, and income level. Depression was measured using the Beck Depression Inventory, a widely validated 21-item self-report scale with scores ranging from 0 to 63; scores of 0 to 13 were classified as no or minimal depression, and 14 and above as depressed, with additional categories of mild, marginal, moderate, severe, and extremely severe. Prior validation work has reported that the scale's test-retest reliability ranges from 0.73 to 0.92, with an internal consistency of around 0.90.

The university's institutional ethics review committee approved the study, and the National Commission for Science, Technology, and Innovation issued a research licence, as well as endorsement letters from both participating CBOs. Given the criminalisation of consensual same-sex conduct in Kenya, questionnaires were coded rather than named and administered via secure, individually accessed digital links by trained research assistants who were already familiar with the target population. Participants provided informed consent, had the option to withdraw without consequence, and those with severe symptoms were referred for appropriate clinical care. Data were analysed in IBM SPSS Statistics version 29, using descriptive statistics, chi-square tests of association between depression and each sociodemographic variable, a composite socioeconomic risk index, and ordinal logistic regression modelling depression severity against all six predictors concurrently.

RESULTS

324 valid responses were analysed from 425 targeted questionnaires, representing a response rate of 76.2%. The majority of respondents (37.2%) had diploma-level education, followed by secondary-level education (26.6%), with 9.0% reporting postgraduate qualifications. Renting was the most common living arrangement (72.5%), with home ownership accounting for only 4.4%. Nearly a third (32.6%) had no health insurance, 56.2% paid for healthcare out of pocket, and income was concentrated at the lower end, with 41.8% in the lowest income category and part-time employment being the most common status (46.0%).

Table 1. Prevalence of Depression Among LGBTQ+ Youth (N=324)

Severity level	n	%
Low / no depression (0–13)	129	39.8
Mild (14–19)	35	10.8
Marginal (20–25)	50	15.4
Moderate (26–31)	49	15.1
Severe (32–39)	36	11.1
Extremely severe (≥ 40)	25	7.7
Depressed (total)	195	60.2

60.2% of respondents met the criteria for depression: 10.8% mild, 15.4% marginal, 15.1% moderate, 11.1% severe, and 7.7% extremely severe. When the moderate-to-extremely-severe categories were combined, 34% of the total sample scored at a level that would normally require structured clinical support rather than purely informal psychosocial care. This overall prevalence is several times higher than the WHO's (2022) global adult estimate of approximately 4-10%, and broadly consistent with the 50% one-year prevalence Stonewall (2023) reported among UK LGBTQ+ adults, a difference plausibly explained by the shorter, two-week symptom window and higher clinical threshold applied by the depression scale used here.

Table 2. Depression Status by Sociodemographic Characteristics

Variable	Category	Depressed n (%)	χ^2 test
Education level	Primary	19 (65.5)	$\chi^2=6.44$, df=5, p=.266
	Secondary	51 (59.3)	
	Diploma	67 (56.3)	
	Bachelor's degree	40 (71.4)	
	Postgraduate	15 (51.7)	
Household size	1–2 people	36 (61.0)	$\chi^2=0.73$, df=3, p=.866
	3–10 people	82 (60.4)	
	>10 people	6 (50.0)	
Living arrangement	Own/buying home	11 (78.6)	$\chi^2=5.34$, df=4, p=.254
	Renting	133 (58.8)	
	Living with family	17 (73.9)	
Health insurance	None	58 (55.2)	$\chi^2=1.63$, df=2, p=.444
	Private	72 (63.7)	
	Government	60 (59.4)	
Healthcare payment	Out-of-pocket	96 (56.1)	$\chi^2=1.13$, df=1, p=.287
	Insurance coverage	83 (62.9)	
Employment status	Unemployed	30 (54.5)	$\chi^2=5.21$, df=4, p=.266
	Part-time employed	83 (56.5)	
	Full-time employed	71 (67.6)	
Income level	Lowest	82 (61.7)	$\chi^2=5.96$, df=4, p=.202
	Level 2	58 (63.0)	
	Level 3	9 (45.0)	
	Level 5+	38 (62.3)	

None of the seven characteristics examined showed a statistically significant association with depression status (all $p>.05$). Depression percentages ranged narrowly across categories with no consistent pattern by income or education; notably, full-time employed respondents recorded a higher depression rate (67.6%) than unemployed respondents (54.5%), the reverse of the pattern generally assumed in general-population research, though the difference was not significant.

Table 3. Mean Depression Score by Employment, Income and Insurance

Variable	Category	N	Mean score (SD)
Employment	Unemployed	55	16.56 (11.83)
	Part-time employed	147	18.02 (13.91)
	Full-time employed	105	20.70 (12.91)
Income	Lowest	133	18.30 (12.99)
	Highest	61	20.61 (13.24)
Insurance	None	105	17.93 (13.09)
	Private	113	19.37 (13.62)

Table 4. Depression by Number of Cumulative Socioeconomic Risk Factors

Risk factors (lowest income, unemployed, no insurance)	N	Depressed %	Odds ratio (ref: 0)
0	108	62.0	Reference
1	143	58.7	0.87
2	60	61.7	0.98
3	10	40.0	0.41

Mean scores rose modestly with employment stability and private insurance rather than falling, the reverse of the usual pattern; the small subgroup differences did not reach statistical significance but were directionally consistent across two independent indicators. A composite risk index combining lowest income, unemployment and lack of insurance (summed 0–3) showed no rising depression gradient at all; if anything, the odds ratio fell to 0.41 among the small group carrying all three risk factors. Severe and extremely severe cases occurred in every category examined, including the fully employed and privately insured, indicating no protective effect of material resources against the more clinically significant forms of depression.

Table 5. Ordinal Regression: Predictors of Depression Severity

Predictor	OR (95% CI)	p
Income level	0.99 (0.90-1.08)	0.749
Employment status	1.17 (0.92-1.49)	0.192
Health insurance	1.06 (0.81-1.39)	0.658
Education level	1.00 (0.82-1.21)	0.974
Living arrangement	0.91 (0.76-1.09)	0.325
Healthcare payment	1.20 (0.78-1.85)	0.417

A model regressing depression severity on all six predictors simultaneously was not statistically significant overall (LR $\chi^2[6]=4.02$, $p=.673$; pseudo $R^2=.004$), and no individual predictor reached significance, with every confidence interval spanning 1.00. This does not mean depression severity is unpredictable; it means these conventional variables did not capture what was actually driving it, since the questionnaire did not measure stigma, concealment, rejection or victimisation.

DISCUSSION

The central finding, a 60.2% depression prevalence among LGBTQ+ youth at two Mombasa CBOs, sharpens with instrument-based precision the more qualitative, stigma-focused evidence previously reported from Kenya (Korhonen et al., 2022; Chitembo et al., 2022) and aligns with the broader regional pattern (Logie et al., 2022; Müller et al., 2021). More analytically important is the second finding: depression was distributed almost uniformly across every sociodemographic characteristic examined, and no bivariate test, risk index or regression model identified a significant predictor. Read through Minority Stress Theory, this is not a null result to set aside; a sample restricted to individuals who already share identity-related stress exposure would be expected to show little sociodemographic differentiation in depression, precisely the pattern observed here (Pachankis, 2015; Pachankis et al., 2023).

Two results deserve comment. First, full-time employed and privately insured respondents scored numerically worse than their unemployed and uninsured counterparts, the reverse of typical general-population findings; greater institutional integration may expose LGBTQ+ youth to more situations requiring concealment or defence of identity, itself a proximal minority stressor (Hatzenbuehler & Pachankis, 2021). Second, the absence of a rising depression gradient with cumulative socioeconomic risk is difficult to reconcile with a standard social-determinants account but is readily explained if minority stress functions as a baseline exposure common to the whole sample.

Practically, these findings argue against socioeconomically targeted screening, which would miss the majority of affected youth given how evenly depression was distributed, and instead support universal, CBO-administered screening of all LGBTQ+ youth regardless of income, education or employment profile. They also point to a specific research priority: developing and validating minority-stress-specific assessment tools, covering stigma exposure, concealment, family

rejection and social support, that could be paired with the Beck Depression Inventory to test directly the explanation this study's sociodemographic data could only support indirectly.

CONCLUSION

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The convenience sample cannot be assumed representative of LGBTQ+ youth in Kenya more broadly, and findings generalise cautiously to youth accessing similar CBOs. Depression was assessed only by self-report, which can be affected by recall and social desirability in a population accustomed to concealment. The Beck Depression Inventory was developed and validated primarily in North American clinical populations, and while it has been used extensively across sub-Saharan Africa, its item content may not carry identical meaning for Kenyan LGBTQ+ youth navigating a distinct set of religious, familial and legal pressures. The questionnaire also did not measure stigma, concealment, rejection or social support directly, so the absence of significant sociodemographic predictors is informative about what did not explain depression but cannot on its own confirm minority stress as the mechanism.

RECOMMENDATIONS

Three recommendations follow. First, CBOs and the Ministry of Health should establish routine, universal depression screening using validated tools such as the Beck Depression Inventory as a standard part of intake, administered by trained CBO staff rather than mainstream health facilities given the legal risks direct state involvement could introduce. Second, screening resources should not be preferentially targeted toward the conventionally disadvantaged, since every LGBTQ+ youth accessing CBO services should be considered at elevated risk regardless of socioeconomic profile. Third, researchers should develop and validate minority-stress-specific assessment tools suited to the Kenyan context, since this study's null sociodemographic findings point directly to the explanatory gap such tools would need to fill.

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